REV. FEBRUARY 1, 2015
MANUAL LETTER #05-2015
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
RESPITE SUBSIDY PROGRAM
464-000-4

Nebraska Department of Health and Human Services
Form CFS-22 BILLING DOCUMENT INSTRUCTIONS
Lifespan Respite Subsidy Program

Revised 01/2015

See attached sample Billing Document CFS-22 for section detail (Jane Care Recipient).

1. Check the box for **Lifespan Respite Subsidy.**

2. Complete the **name, client ID #, phone number, Email address, and mailing address** for the client, the person with the special needs.

3. Complete **name, email address, and mailing address** for the provider, the person providing the services.

4. Complete the **name and payee ID #** of the person being paid. Payee ID#s appear on our check stubs. If a new provider and no payee ID# yet see # 5 below.

5. **If this is a new provider OR a new person to be paid, provide the Social Security # or Federal ID # in the box provided.**

6. **Check the box** indicating who we are to pay. If no box is checked, the billing document will be returned.

7. **Service details**:

   A. **Service performed**. Circle Respite.
   B. Enter the **month and year of service**. Enter the **date of each service**.
   C. Enter the **number of units**, such as hours, days, etc.
   D. Enter the **rate** charged per unit.
   E. **Total** each line.
   F. **Total the bill**.

8. **Two signatures and dates** must be on the bottom of the form. The first signature is the client's, the second is the provider's. **Payment will not be made if the provider signed and dated the form after the client.*

9. If we are paying more than one provider, use a separate form for each one.

10. If we are reimbursing you, attach receipts, or the provider's signature is required.

11. Use a separate claim form for each month. Submit white copy to DHHS and Payee keeps yellow copy. Bills must be submitted within **60 days of the first date of service**. This is a change in policy effective Spring 2014.

Department of Health & Human Services
Division of Children & Family Services, Economic Assistance
P.O. Box 95026
Lincoln, NE 68509-5026

OR

Email to dhhs.cfs22@nebraska.gov

12. Billing Document may be submitted on any day of the month after respite has been provided. NOTE: first week of the month the highest volume is received resulting in slower payments. Payment Specialist is responsible for paying bills from several programs and not just Lifespan Respite Subsidy. ***Do not call Program staff checking on when you will receive payment until a minimum of 30 days has passed since DHHS received Billing Document and you have still not received payment.***

If you have any questions about the completion of the Billing Document please contact us at 1-844-807-1197 and ask for Linda Lehde, Lifespan Respite Subsidy Social Services Worker at (402) 471-9188 or dhhs.respite@nebraska.gov. **Incomplete or improperly completed forms must be returned for correction**.

Call a Respite Network Coordinator in your area at 1-866-RESPITE (1-866-737-7483) to become a Nebraska Lifespan Respite Network-approved provider or to discuss respite resource needs. You may also visit the DHHS supported website "Nebraska Resource and Referral System" at https://nrrs.ne.gov/respitesearch/. This free service will assist you 24/7 in finding Network-approved respite providers that best fit your needs and location. You can easily search for respite resources and supportive services throughout Nebraska on the site.

NEBRASKA RESPITE NETWORK
1-866-RESPITE
(1-866-737-7483)

Nebraska Department of Health and Human Services
BILLING DOCUMENT

Department of Health & Human Services
DHHS
NEBRASKA

1) **Check One:**
- ☐ Disabled Persons and Family Support Program
- ☑ Lifespan Respite Subsidy Program
- ☐ Medically Handicapped Children's Program
- ☐ SSI/Disabled Children's Program

Office Use Only
CFS-22 ID #:

Client Name:	Client ID #:	Client Phone #:
Jane Care Recipient	Required	(xxx) xxx-xxxx

2)

Parent/Legal Guardian/Conservator/Authorized Representative: (One name only)	Client Email Address:		
Name provided on Program Application	xxx@xxxx.com		
Client Mailing Address: ☐ **Check if the address has changed since last payment made**	City:	State:	Zip:
112 Main Street	My Town	NE	xxxxx-xxxx

3)

Provider (Name of person providing the service)	Provider Email Address:		
Rhonda Respite	xxx@xxxx.com		
Provider Mailing Address: ☐ **Check if the address has changed since last payment made**	City:	State:	Zip:
P.O. Box xxx	My Town	NE	xxxxx-xxxx

4)

Payee: (Name of person to be paid)	Payee ID#: (# listed on last check or EFT Notice)	If NEW payee, a Social Security # or a Federal Tax ID# is required: 5)
Family and Provider Decision	Required	Only complete if first time Payee

6) Person to be paid is the: (check one)
☐ Provider ☐ Client ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Authorized Representative

INSTRUCTIONS: Submit one Billing Document per month for each provider.
Bills must be submitted within 60 days of the date of service.

7)

AUTHORIZED SERVICE PERFORMED List below one of the following services: Respite, Personal Care, Housekeeping, Home Delivered Meals, Sibling Care, Mileage (for med care), Meals (for med care), Lodging (for med care), Incontinence Supplies	**DATES** List date of service separately (Include month, day, year)	**TOTAL NUMBER OF:** List the number of hours, days, miles, or meals for each service (Specify hours, days, miles or meals after each number)	**COST** List the amount charged per hour, day, mile or meal	**TOTAL AMOUNT**
A) Respite	B) 4-1-2014	C) 4 hours	D) $10.00	E) $40.00
	4-6-2014	3.5 hours	$10.00	$35.00
	4-19-2014	5 hours	$10.00	$50.00
Office Use Only. Authorized by:	Office Use Only. Authorized Date:	**TOTAL BILLED**		F) $125.00

The Client/Parent/Guardian/Conservator/Authorized Representative must verify that this billing is accurate.
For Businesses, a W-9 form will be required if you are a new provider, have an address change or a name change.
Anyone who files a false claim may be prosecuted for Fraud.

8)

Adult Client/Parent/Legal Guardian/Conservator/Authorized Representative's Signature:		Date: (on/after last date of service)
Required		Required
Provider Signature:	Provider Phone #	Date: (on/before client signature)
Required	(xxx) xxx-xxxx	Required

Billing documents will be returned if provider signs and dates before the client/authorized representative.

Distribution: WHITE - DHHS Central Office; YELLOW - Payee

CFS-22 Rev. 1/14 (22002)
(Previous version MHC-24 should NOT be used)

464-000-4 Form CFS-22, “Billing Document” is available at http://public-dhhs.ne.gov/FORMS/Home.aspx. Search for Form CFS-22.